

# GROUP AND MILIEU THERAPY FOR VETERANS WITH COMPLEX POST- TRAUMATIC STRESS DISORDER

BY JONATHAN SHAY, M. D., PH.D.

Department of Veterans Affairs Outpatient Clinic,  
Veterans Improvement Program (VIP),  
Tufts Medical School Departments of Psychiatry, Boston

AND JAMES MUNROE, ED.D.<sup>1 2 3 4</sup>

Department of Veterans Affairs Outpatient Clinic,  
Veterans Improvement Program (VIP),  
and National Center for PTSD Behavioral Sciences Division, Boston.

### INTRODUCTION

In this chapter we do not claim to address treatment issues for all trauma survivors, nor do we aspire to see the world through the tiny keyhole of the clinical population with which we work: American male combat veterans of the Vietnam War (hence the masculine pronoun throughout) with chronic posttraumatic stress disorder (PTSD) and “enduring personality change after catastrophic experience” (WHO, 1992, p. 209). If what we say translates to the

reader’s other clinical or public health populations, we are gratified, but the reader must make the translation. In part, this reflects our philosophic position that we should not pretend to universal, eternal scientific knowledge about these things, nor shall we covertly claim this knowledge through the use of an unlocated authoritative textbook “voice.” We have worked together for almost ten years, and speak from a specific time and place with lives and works in progress. When later in this chapter we speak of our treatment program called “VIP,” it is not to advertise

---

<sup>1</sup>Neither author has past, present, or anticipated relationship to the manufacturer of any medication or class of medications mentioned in this chapter.

<sup>2</sup>The views expressed here are those of the authors, and should not be taken as official views of any governmental or academic institutions.

<sup>3</sup>The authors wish to thank the veterans of the VIP and the rest of the VIP clinical team, Lisa Fisher, and Christine Makary. We acknowledge valuable critical input from a number of Professors of Philosophy, who have been kind enough to vet an earlier draft of this chapter for “howlers.” Thanks (in alphabetical order) to Eugene Garver, Jennifer Radden, Amélie Rorty, and Charles Young. We also thank the following for their critical advice: J. Douglas Bremner, Susan Brock, Michelle Citron, Vicki Citron, Greg Febbraro, Faris Kirkland, Hannah Shay, and Tamar Shay. Thanks also for insights from classicist, Professor Erwin F. Cook.

<sup>4</sup>Editors’ Note: In view of the comprehensive nature of this book, and, as many clinicians have an interest in group interventions that are intended to address the problems of Vietnam veterans, this chapter describes a highly regarded multi-faceted program that deals with the psychopathology of traumatized veterans. While the efficacy of the treatment that is described has not been subjected to scientific scrutiny, it is hoped that this information may stimulate efficacy-based research involving group therapy for traumatized veterans.

for patients nor even to offer it as a model to be cloned, but rather as an example to be assimilated to the character of the reader's patients, colleagues, and institutions.

Personality ("character") changes have made these veterans huge consumers of resources for hospitalization, incarceration, family and workplace disruption, and clinical crisis management. Of all aspects of these veterans' psychological injuries, their enduring posttraumatic personality changes—damage to good character—impose the greatest social, economic, political, and clinical costs. In our opinion, these veterans' damaged characters can be restored—well enough, at least, to provide a safer world for their families, employers, and communities—and well enough to enhance the quality of life as they themselves experience it. However, as we shall describe below, this restoration entails clinical practices at odds with much of our culture's normative value pattern for the professional.

Our patients were all participants in the exercise of state military power in and around Vietnam between 1965 and 1972, and trace their injuries to this participation. Because of the dominating element of power, the context of their injury is thus in every sense political; we shall argue that important features of their injury are political. We shall take the position that the treatment we provide is political—we consciously foster an empowered community among the veterans that we treat. Our position with respect to the veterans is one defined by a very ancient term. We aspire to be "*rhêtor*" (i.e., democratic persuader) in the rich form laid out by Aristotle in the *Rhetoric*: Our task is to create trust (*pístis*) for fellow citizens. As Aristotle uses "*pístis*" in the *Rhetoric*, it means variously, trust, persuasion, proof, credibility, belief, and the processes or means that bring about persuasion (Garver, 1994b, p. 142; Carey, 1996, p. 299). For Aristotle, the contrasting opposite to the *rhêtor* was the *sophist*. The *sophist* was, in quite modern terms, a professional who applied a *technê*, that is, a teachable, ends-rational skill available for hire from the holder of credentials certifying mastery (Garver, 1994b, pp. 206–231).

This chapter addresses the encounter of the psychologically injured Vietnam combat veteran and the mental health professional.

## The Core Treatment Issue Is Social Trust

We regard the key manifestation of the veterans' psychological injuries in the treatment setting is destruction of the capacity for social trust. How the veterans' incapacity for trust plays out in the family, workplace, government office, commercial establishment, has been well described elsewhere (Lifton, 1973; Mason, 1990; Matsakis, 1996; Shatan, 1985). In the clinic, social trust is the readiness to repose trust in professional credentials, institutional position, and the value pattern of the professional. We shall explain below what we mean by the value pattern of the professional. But at this point it suffices to say that the veterans we work with have had the real experience of being exploited and betrayed by people holding the right professional credentials, in fulfillment of their institutional positions, in a context of 24-hour-a-day danger that meant that there was "no safe place." Our veterans live in perpetual expectation of physical attack, interpersonal coercion, and institutional exploitation, deceit, and betrayal. Because their psychological injuries have destroyed social trust, the most severely injured veterans are least able to get and retain access to treatment.

The combination of PTSD symptoms (American Psychiatric Association, *Diagnostic and Statistical Manual*, 1980, 1987, 1994, hereafter collectively "DSM") plus personality changes has been well characterized by others under the terms "complex PTSD," "DESNOS," and other locutions reviewed by Herman (1993). We offer nothing new here in nosology. This combination has not been accepted in the DSM, but not for lack of its being described and studied. In the rest of this chapter we shall use Judith Herman's term "complex PTSD" for our patients with post-combat complex PTSD. Many veterans who have served in war do not have even "partial" PTSD, and many who meet the full diagnostic criteria for PTSD do not have complex PTSD. Our patients meet the DSM criteria for PTSD and have in addition other bio-psychosocial changes that Herman (1992b, 1993) describes. These changes encompass:

- Altered affect regulation, such as persistent dysphoria, chronic suicidal preoccupation, explosive or extremely inhibited anger, which may alternate

- Altered consciousness, such as transient dissociative episodes, amnesia or hypermnesia for traumatic events
- Altered self-perception, including a sense of helplessness, paralysis of initiative, shame, guilt, and self-blame, a sense of defilement or stigma, a sense of complete difference from others, which may include sense of elite specialness
- Altered perception of the perpetrator, including preoccupation with revenge and/or idealization or paradoxical gratitude toward the perpetrator
- Altered relations with others, such as repeated search for a rescuer, which may alternate with isolation and withdrawal, persistent distrust, repeated failures of self-protection
- Altered systems of meaning, including loss of sustaining faith, sense of hopelessness and despair
- Somatization

### Destruction of Normal Narcissism

Mental health professionals who have casually encountered combat veterans with PTSD are often unpleasantly struck by their "narcissism," as manifested by some of the following:

- Demands for honor and acknowledgment
- "Entitlement"
- Self-important claims to having been players in the most significant events in human history
- Readiness with which they take offense at what they take to be slights
- Occasional insistence that they will deal only with the Chief of Service ("the head of the snake")
- "Global" destructiveness of their fantasies, wishes, and, occasionally, behavior
- Vulnerability to collapses of morale which leave them so apathetic that they cannot want or will anything at all
- Hypochondriacal preoccupations and psychosomatic disorders

This unappealing portrait of "narcissistic" combat veterans has important roots in reality, which if properly understood, teach us much about working with them and much about ourselves. The word "narcissism" was introduced in the writings of late

nineteenth century psychologists and sexologists, primarily to talk about auto-erotic phenomena. It was used theoretically by Freud in several ways including his developmental theory of normal infancy. The generation of psychoanalysts after Freud, most notably Kohut, but many others as well, decisively broke the concept away from its sexological roots and associated the word with the rise and fall of self-esteem, self-confidence, and self-respect. More generally the term came to be associated with a psychology of the experience of the self in general, including healthy self-esteem, self-confidence, and self-respect. The concept also broadened beyond the evaluative sense of pride and shame, to include the strength or weakness of the self's coherence, continuity in time, moral agency, creative efficacy, and the capacity for empathic grasp of other people as real and significant (Pulver, 1970). Thus narcissism is not exclusively an infantile or pathological phenomenon, but infuses essential elements in human flourishing. When clinicians use the term "narcissistic" to damn veterans who are easily enraged, boastful, or demanding, it is as though they have utterly forgotten the importance of narcissism in any good life.

In the post-Freud sense of the word, the psychological issues involved in combat trauma, and in recovery from it, are in the territory of narcissism. We strongly agree that narcissism is part of the psychic economy of the healthy adult, and wish to point out that it is intimately bound up with the moral and social world that the adult inhabits. As such, "narcissism" is simply the most recent term for a notion with a long history in the attempts to understand the human being. Working backwards in time, this notion has been called "desire for recognition" (Hegel), "*amour-propre*" (Rousseau), pride or vainglory (Hobbes), "*thumoeidés*" (Plato), and "*thumós*" (Homer).

The features of the normal adult world which control narcissistic emotions and moods are ideals, ambitions, and affiliations. Here, when we use the word "character," we refer descriptively to the following, taken together—

- The historically and socio-culturally constructed content of the commitments embodied in ideals, ambitions, and affiliations

- The intensity with which the commitments are energized
- The narcissistic emotions aroused by cognitive appraisal of the condition (particularly improvement or deterioration) of these commitments in the world

How stable character is, depends largely on the ecology of social power, upon the good-enough fulfillment of the culture's moral order by those who hold power. The normal adult's cloak of safety and guarantor of narcissistic, hence characterologic, stability is the normative structure of the society, its implementation by powerholders, and the concrete social support of a face-to-face community. Good-enough realization in the world of these commitments is the foundation of ordinary self-respect and of the sense of self-worth that we expect in the normal adult. Sudden, undreamed of fulfillment in any of these three realms will usually make a healthy adult euphoric. And serious, high-stakes destruction in any of these three realms—especially when the threat originates in betrayal of the moral order by powerholders or in abandonment by those to whom one is attached and socially affiliated—is the basis of the damaging changes to character which are the principal subject of this chapter. We do not offer character stability as a goal or good in itself—the posttraumatic changes in character we attempt to reverse are sometimes horrifyingly robust—and it is only the continuing fluidity of adult character that provides an opportunity for treatment.

Some readers will reflexively reject the very idea that good character, once formed by good upbringing in childhood, can ever be damaged by any events that merely happen to the adult. The idea that adult good character is inviolable is an old and disputed philosophical position or a useless tautology, not a scientific fact (Shay, 1995b).

Narcissism, the allegedly most “primitive” of psychological phenomena, much entwined with the body, is therefore deeply enmeshed with the social, moral, and political. Social betrayal and isolation in a high-stakes situation has profound physiological, as well as psychological, consequences. To chronically live in “no safe place,” made unsafe by other people, damages the body.

In ancient Greece, the emotions and commitments embodied in ideals, ambitions, and affiliations were subsumed under the single Homeric word *thumós* (i.e., spirited self-respect). This has often been unhelpfully translated as the single word “spirit.” It has also been translated as “temper,” “*animus*,” “spiritedness,” “aspiration.” Professor Amélie Rorty (personal communication, 1996) has been kind enough to provide a more informative translation: “the energy of spirited honor.” To be entirely deprived of honor has been described as “social death” (Patterson, 1982). It was Achilles’ “large” *thumós* (*Iliad* 9:255) that led him to become so enraged with Agamémnon when the latter betrayed the shared military norms of their culture by dishonoring him and seizing the prize of honor awarded to him by acclaim of the troops. Plato’s Socrates posits the “high-spirited principle” (*thumoeidés*) as one of the three divisions of every human psyche in his famous tripartite division of the soul (*Republic* IV, 435e–444e). In *Politics* VII.6.1327b39ff Aristotle says, “*Thymos* is the faculty of our souls which issues in love and friendship—it is also the source—of any power of commanding and any feeling for freedom.” (Garver trans. 1994a, p. 177n8) The normal narcissism of the healthy adult can now help us understand characterological changes in complex PTSD after combat.

We hold that the conditions which cause complex PTSD (persistent human betrayal and rupture of community in high-stakes situations of captivity) destroy *thumós* and normal narcissism. Modern battle is a condition of captivity (even when it has been entered voluntarily), a fact that has escaped notice because the captives move about in the open carrying powerful weapons, and because the role of captor is cooperatively shared by the two enemy military organizations which are presumed to cooperate in nothing (Shay, 1994). Modern combat itself is a condition of enslavement and torture. Until we end the practice of war itself, this will be the case.

What replaces normal narcissism when it is impaired? Our own answer to this must be taken as limited by the patient population we work with, who over the decades have sought treatment and been involuntarily enrolled in the mental health system. Most have cycled repeatedly through several of the following, sometimes quickly, sometimes slowly—

- Demoralization [*athumía*], death to the world, apathy, ennui, and aboulia, anhedonia, dysthymia—sickened *thúmos*
- Loss of self-respect
- Self-loathing
- Social withdrawal
- Pervasive “raw” feeling of vulnerability
- Blind obedience, which may turn into a fanatical “mission”
- Grandiosity and entitlement
- Rage at small slights, disappointment, lapses
- Coercive attempts to establish power dominance
- Coercive demands for respect, honor, acknowledgment
- Danger-seeking, fight-seeking
- Mortal risk-taking to divine the status of one’s “luck”

It is possible that most men who remained in only one of these would never have come to our attention in a specialized PTSD clinic, because they would be dead, incarcerated, stably reclusive, famous and powerful on a small or large scale, or misdiagnosed as schizophrenic. If complex PTSD after combat appears to be marked by repetitive cycling, it may be because the veterans themselves and the social system direct elsewhere those who do not cycle.

### “Combat Ages You”

Several pieces of the personality pattern we have described here were touched on with painful clarity by Aristotle when he sketched his portrait of the elderly in the *Rhetoric* II.13.1389b13ff:

*“Because they have...been deceived many times... they are malignant...[that is, they] interpret everything in the worst light. Furthermore, they are excessively suspicious because of their lack of trust (apistian), and lacking in trust because of their experience.... And they are small of soul.... And they are self-loving more than is appropriate; for this too is a kind of smallness of soul.... [T]hey think every suffering is waiting for them.... For this reason they are given to grieving, and are neither charming nor fond of laughter.”* (Nussbaum translation, 1986, p. 338, emphasis added)

It is not mere word-association to quote what we have often heard veterans say: “Combat ages you. You get old real fast.”

Rupture of community and “betrayal of what’s right” (Shay, 1994) are responsible for layering the characterologic, narcissistic injury onto PTSD that the intrinsic terror, grief, privation, and horror of war inflicts on those who fight. In the discussion that follows, we focus on community, because restoration of community is the core of our treatment model.

### Destruction of the Combatant’s Community

**Destruction of Unit Cohesion.** In Vietnam, whatever group cohesiveness developed within small units was left behind as soldiers rotated home quickly by air, as individuals rather than as a unit (Shay, 1994). They returned truly alone, in planes packed with strangers. There was no “debriefing,” no opportunity to communalize the terrors, the losses, the might-have-beens and should-have-dones. A recent paper by a leading military historian and two active duty Army officers in *Parameters: Quarterly Journal of the US Army War College* speaks of debriefing, decompression, and three forms of validation (substantive, institutional, and memorial) as essential for soldiers returning from combat duty (Kirkland, Halverson, & Bliese, 1996). These protective practices of cohesive military units were systematically denied to American combatants returning from Vietnam, through a combination of neglect, ignorance, culturally driven blindness, and unintended consequences of well-intended policies. We shall return to these practices of cohesive units in our discussion of the VIP treatment model for combat veterans.

### Aversion to Returning Veterans Is an Old Story.

Acts of war generate a profound gulf between the combatant and the community he left behind. The veteran carries the taint of a killer, of blood pollution, that many cultures other than our own recognize in purification rituals. Both he and his community may question the wisdom of return. The community worries about his control. The veteran, knowing what he is capable of, may also fear losing control. He may

fear that if people knew what he had done, they would reject him or even lock him up. Both the veteran and the community collude in the belief that he is "no longer one of us." Many veterans express the feeling that they died in Vietnam and should not have returned.

Both the trauma of war, and recovery from it, are social, not individual events. Many authors have emphasized the importance of social supports and community in recovery from traumatic events (Catherall, 1989; Erikson K. T., 1976; Figley, 1988; Janoff-Bulman, 1985; Keane, Scott, Chavoya, Lamparski, & Fairbank, 1985; Lifton, 1967, 1979; Shatan, 1985; van der Kolk, Brown, & van der Hart, 1989). Janoff-Bulman (1992) proposed that trauma undermines the survivor's basic assumptions that the world is benevolent, meaningful, and that the self is worthy. Erik Erikson's (1959; 1963) theory of normal psychosocial development describes "basic trust" as the first of eight stages. It is at this stage that the child develops a sense of community which then allows further development to occur. The parents give the child "a firm sense of personal trustworthiness within the trusted framework of their community..." (Erikson, 1959, p. 63). The parents also communicate "a deep, almost somatic conviction that there is meaning to what they are doing," (Erikson, 1963, p. 249) and a belief in "Fate's store of good intentions" (Erikson, 1959, p. 62). Collectively, these authors describe the link between trauma and loss of community. It is not the loss of a specific community, but the loss of the ability to belong to any community. Belonging to a community requires the mutual belief that members will look out for each other.

Some of the disconnection and alienation between returning Vietnam veterans and their home communities came from the rapid social changes at the time and the gulf of experience that separated veterans from their peers. However, it is more nearly typical for returning U.S. war veterans to be shunned by the communities they returned to (Severo & Milford, 1990), than to be celebrated by them. The experience of the World War II veterans—the fathers of the Vietnam veterans—is the historical anomaly. At the end of World War II, politicians, with fresh memories of the Bonus Army of World War I veterans, worried about so many returning soldiers looking for jobs.

Congress appropriated unprecedented benefits, which then declined in real terms to half their value by the time of the Vietnam War.

Farmers from the Revolutionary War returned to find banks foreclosing their farms because the money the government gave them was no good. Civil War veterans had trouble finding employment and were accused of being drug addicts. Supposedly, our word "hobo" comes from homeless Civil War veterans—called "hoe boys"—who roamed the lanes of rural America with hoes on their shoulders, looking for work. World War I veterans who marched on Washington and camped on the Mall to demand their bonuses had their camp burned and were driven out with tanks and bayonets. Korean veterans were accused of being too weak to win, and in the wake of McCarthyism, were suspected of communist sympathies from brainwashing as POWs.

With increasing polarization over the Vietnam War, veterans returned home to protesters who accused them of being torturers, perpetrators of atrocities, and baby killers. For every returning veteran who encountered this personally, there were many more who saw highly selected scenes of it in the news or heard n<sup>th</sup>-hand stories. The media presented a barrage of images portraying the Vietnam veteran as crazy, drug addicted, and violent. For many veterans who had joined up because it was their duty as citizens, who had grown up on John Wayne and Audie Murphy, and because they thought what they would be doing was right, rejection by the community was infuriating. In their fathers' VFW and Legion posts, some were greeted with derision even more devastating than the criticisms leveled by the war protesters: "We won our war. What is wrong with you?"

The supposedly traditional idea of honoring returning veterans ran afoul of deep divisions over the justice and wisdom of the war as a whole, making honor to the veterans seem an endorsement of the war policy. From the hawks on the political right to the doves on the political left, the nation as a whole lost sight of the fundamental importance of social esteem—embodied no less in private gestures of respect than in public rituals of honor and recognition—in rebuilding the capacity for social trust in a person who has come home from war.

### *Consequences of Shattered Trust—No Safe Place.*

When “basic trust” is destroyed, what replaces it is perpetual mobilization to fend off attack and to figure out other people’s trickery. In the world of Homer’s warriors, the world was seen primarily in two dimensions, *biê*, (might) and *mêtis* (cunning); Achilles embodied the former and Odysseus the latter. Our patients construct the world similarly. Civil society, founded in a third dimension of trust and trustworthy restraints, seems to them a deceptive veneer to hide a violent and exploitative reality (Munroe, 1991). Alertness and suspicion anticipate attack and deception. This is easily mistaken for paranoia, but in our patients it is the persistence into civilian life of a valid adaptation to the real environment of war that they have experienced. Lying and deceit are valuable military skills, for which Odysseus boasted, “Men hold me formidable for guile...this fame has gone abroad to the sky’s rim.” (Homer, ca. 800 B. C. E./1961, Book 9, Lines 20f). In war, “they”—the enemy—really are out to kill you. The modern soldier’s own military organization propels him, terrified, into the presence of that enemy. After such experience, friendliness and cooperation may only look like manipulations to trick inexperienced rubes into a position where they can be exploited or injured.

### *What Community Offers.*

Communities offer safety. At the crudest level of physical security, other people share alertness to threat, so that each individual does not have to be constantly vigilant. Within the defensive group, safety lies in the predictability of boundaries and normative restraints of behavior. But beyond this there may be some as-yet unclarified aspect of human brain biology at work in the subjective sense of safety that accrues when there is mutual social recognition and esteem. To be secure in the esteem of your community and of your identity within it—basic satisfaction of *thumós*—reads as being secure, *simpliciter*. In our ancestral environment where the human brain evolved to its present form, this connection may have prevailed at the most basic level of survival. Contrawise, moral danger of betrayal and abandonment are read in the body as physical danger. Moral betrayal, social isolation, and lack of social support enter into a self-feeding cycle with fear and suspicion of other people.

### **How Lack of Social Trust Becomes a Problem for Mental Health Professionals**

We believe that the lack of social trust leads to a characteristic impasse between mental health professionals and combat veterans with complex PTSD. We also believe that this impasse is the main obstacle to treatment.

We maintain that the veteran is, by reason of injury inflicted by real experience in war of betrayal by those with credentials and institutional position, unable to trust clinicians on the basis of their credentials and institutional position. The veteran enters the relationship with a big question mark after the word “trust”—Should I trust you?—and sets about making observations and setting up tests of trust to answer the question.

On the other hand, the clinician has ideals of professional conduct, feels justifiably proud of having fulfilled ambitions to attain a responsible job title, usually aspires to advancement in his or her institution and profession, and draws a sense of personal value from membership (affiliation) in the collectivity of the profession. In a word, the clinician is a normal adult of the modern world with *thumós*—ideals, ambitions, and affiliations. The normal mental health professional takes offense at being treated as a question mark—is this person trustworthy?—rather than as an established certainty, what the clinician is entitled to as a matter of credentials and institutional title. The predictable result is a counter-transference narcissistic rage. The clinician’s hurt feelings in encounters with combat veterans make it easy to apply derogatory labels, such as “borderline,” “character disordered,” “anti-social,” which, despite precise operational definition, mostly function as synonyms for troublesome, bad, vile, evil—and hopelessly untreatable. Diagnoses of personality disorders may carry less information about the veteran than about the way the clinician relates to the veteran.

### **The Paradox of Therapy for Trauma**

Complex PTSD destroys the resources necessary for its successful treatment. Therapy requires that the trauma survivor trust the therapist. We believe that

the veterans have reason, based on their experience, to distrust therapists and to expect to be exploited. They will assume, for example, that a therapist is only interested in them to get a graduate degree, to earn VA salary money, or to write a book. (In the last ten years, J. M. did earn his doctorate, and J. S. did publish a book. Periods of intense anxiety followed both of these events, with veterans watching to see if we each would leave, having accomplished our “real” purpose in being there.)

Therapists usually find that their efforts are not well received. Such “resistance” by combat survivors results in their being declared poor treatment candidates in the medical record, in the informal institutional memory, and often to the veterans’ faces. This is a form of blaming the victim. Therapists who demand “compliance” prior to the establishment of trust and terminate resistant veterans simply add one more layer of violated trust and rejection. Severe trauma requires an infrastructure of trust before traditional therapies can proceed.

We believe that the requirement for trust for treatment to begin is doubly true of randomized treatment trials. In order for a veteran to give informed consent to participate in a randomized trial he must, among other things (a) view written disclosure documents as truthful, (b) believe assurances that he can withdraw from the trial without justification, penalty, or institutional prejudice (“in his record”), (c) believe that the randomization is honest and not rigged, (d) believe assurances that if the active treatment is found beneficial, he will ultimately receive it, (e) be willing to be assessed and, in some studies, even treated by people he has never met and tested, and (f) believe that if something goes wrong, he will not be sacrificed to the goals of the researchers.

We maintain that participation in blind trials requires a degree of trust beyond what many non-traumatized people will extend. Because American Psychiatric Association nosology lumps together simple and complex PTSD, lumps together trauma survivors with and without personality changes, conclusions have been drawn that purport to apply to all patients with PTSD. We believe that veterans with complex PTSD have systematically been excluded and excluded themselves from blind clinical trials.

We submit that we know virtually nothing from blind studies about what works with the very patients who cause us the most worry, the most effort, expense, and trouble.

## VIP TEAM TREATMENT MODEL

### Our Posture toward New Members

Our daytreatment VA staff have treated a large number of veterans with complex PTSD at our Veterans Improvement Program (VIP). Compared to ten years ago, the amount of provocative and dangerous behavior thrown off by members of our program has declined very sharply. The VIP has been running now for almost twenty years and we are unable to parcel out the effect of our good reputation among local veterans, the effects of aging on the veterans, FDA approval of selective serotonin uptake inhibitors, the settling presence of old hands among the veterans in VIP—who function as unofficial peer counselors—and what comes from incremental improvement in our ongoing practices and philosophy. Here are some of the things that we either make explicit or simply have in mind when a new member joins the program:

- We do not expect blind, automatic trust
- We expect that we have to earn trust through time, observation, and testing
- We are not angry back at him for not trusting us
- We expect that trust will be based on observation of how we treat other veterans
- We expect that trust will be based on observation of how we treat each other
- We are willing to be observed and judged

Just as in a military unit, where there is no privacy in the leader’s qualities of trustworthiness—the troops are always watching—the team has no privacy in the way it deals with individual veterans and in the way team members deal with each other. Veterans will mostly do as we do, and little of what we say.

We find the VIP team treatment model is well suited to work with chaotic, crisis-ridden patients and with people who have learned to survive through violence and intimidation. It provides both physical

safety, through its moral effect in veteran community support—the VIP veterans do not tolerate even the smallest threat against the team—as well as psychological safety. The model presupposes that trauma survivors must test the trustworthiness of anyone claiming good intentions, particularly where power is involved. Most of the “acting out” by combat veterans is a test of the team’s trustworthiness. We maintain that trust can only be earned, never assumed from job titles or degrees.

The VIP team treatment model aims at building community among the veterans, demonstrating that they do not have to go through it alone, establishing the value of each veteran’s life to others. In parallel, the treatment team strives for a strong community within itself, and to create a partnership of mutual respect between the veterans’ community and the team community.

Among ourselves and in speaking with veterans we use the three-stage description of recovery, developed by Judith Herman (1992b): Stage I, establishment of safety, sobriety, and self-care; Stage II, trauma-centered work of constructing a personal narrative and of grieving; Stage III, reconnecting with people, communities, ideals, and ambitions. Although we think and speak of these stages, the VIP is not programmatically built around them, and each veteran progresses at his own pace.

### **Stage I: Safety, Sobriety, Self-Care**

We ask the veteran to start with the body and move outward by laying down weapons, maintaining sobriety, terminating current violence as perpetrator and/or victim, meeting health needs, and terminating danger-seeking behaviors. These are goals and results of successful Stage I recovery.

In group therapies with Stage I veterans, we are active and didactic as group leaders, assisting members in gaining authority over the pacing of traumatic disclosure, so it is safe. Meanwhile, we build the theme, “You are not alone; you don’t have to go through it alone.” Like-trauma peer recognition is central at this stage, but disclosure of new trauma history is not an active goal. We relate the inevitable disclosures back to the you-are-not-alone theme and to

the individual veteran’s recognition of links to trauma-driven failures of safety and self-care. We seek the delicate balance between silencing the veteran and allowing him to become flooded by re-living the trauma, which only retraumatizes the patient. We establish the VIP culture of mutual respect for all veterans. No individual’s branch of service, military function, battles, suffering is more “significant” than any other’s.

From the beginning, other veterans provide what Kirkland and his colleagues (1996, p.86) call “substantive validation,” a knowledgeable audience (even if they were not in the same specific units or operations) to whom the veteran’s experience matters, and who are able to support him through the confusion, doubt, and self-criticism that seem intrinsic to having survived the chaos of battle. The team provides practical support for veterans to obtain their military records, unit diaries, and after-action reports when the situation demands. Surprisingly, this often provides the first “institutional validation” that the veterans have been able to take in, sometimes learning for the first time of awards and decorations for valor that they had earned, but had never been personally presented. VIP runs an annual trip to the Vietnam Veterans Memorial (“The Wall”) in Washington, DC, which provides a focus for “memorial validation”—the opportunity to grieve for and commune with dead comrades in a safe and sober fellowship, where the importance of keeping faith with the dead through authentic emotion and respectful remembrance is understood without explanation or justification.

With each other’s support, the veterans finally, decades later, experience the three forms of validation that current U.S. Army doctrine on “combat stress control” declares that every soldier should receive promptly after combat (Headquarters, Department of the Army, 1994). Need this be said? Prevention is better than treatment.

### **Aside: Pharmacotherapy of Combat PTSD**

An integral part of Stage I is the achievement of safety. This means safety for one’s self and safety of others from one’s self. Together, violence and the avoidant strategies that veterans use to protect others

from themselves have blighted the lives of most of the men in VIP. Past pharmacotherapeutic attempts have sometimes been literal chemical straight-jackets, such as dosing with anti-psychotics to the point that extrapyramidal rigidity made assaults physically impossible, or heavy daytime dosing with sedating drugs, such as trazodone. These treatments cut veterans off from themselves and from the world, and have been almost universally rejected by them. We rely more on the moral power of the veteran community in VIP as a robust restraint on violence both in and out of the program, than on such medication. One of us (Shay, 1992, 1995a) has written on our experiences with medication and violence in this group.

Pharmacotherapy provides valuable benefits to men with combat PTSD, providing that a basic principle of the treatment program is followed: Return control to the veterans. In practice this means the following—

We provide a strong, honest educational component on the effects of the various available drugs on combat PTSD. Education includes both prescribed and non-prescribed drugs. The goal is to increase the veteran's intelligent choice on what drugs he is going to ingest. The VIP veteran milieu provides a setting in which veterans who have benefited from medication can pass on this information. Our goals for every veteran who takes medication are that (a) he has made the decision to take it (b) on the basis of trustworthy reasons to suppose that it may improve some aspect of his life and (c) that the drug is worth the risk of side-effects and adverse reactions. We do not force medication on anyone.

The psycho-educational component gives the reasons why certain categories of prescription drugs are relatively contraindicated in combat PTSD, such as opiates, barbiturates, benzodiazepines, and yohimbine (which is absolutely contraindicated). Here, too, the role of other veterans is critical. The purpose is to empower the veterans to speak. In traditional one-on-one medication consultations in a private office behind a closed door, veterans are frequently too mistrustful, or simply afraid. Medication evaluation and consultation in the presence of the other men creates the safety to talk about side-effects and complications, fear of being experimented on, fear of medical

incompetence, despair and shame at the idea of taking psychiatric medications, and so forth. The shift in the power balance in favor of the patients has been an unqualified success, in our experience.

In our experience, the single most useful family of medications for complex PTSD after combat has been the serotonin reuptake inhibitors, of which fluoxetine (Prozac®) is the best known. The principal benefit that the veterans report is a many-faceted change in the economy of anger. A number of our veterans regard fluoxetine as having saved the lives of other people in civilian life, whom these veterans say that formerly they would, literally, have killed. Quite apart from the benefit that the patients themselves receive from reduced explosiveness, the public health benefit in reduced family, workplace, and public violence is one that we dare not ignore.

## **Stage II: Constructing a Cohesive Narrative and Grieving**

When a veteran has tested the community and the team sufficiently, he is often able to venture beyond the safety of we-all-went-through-the-same-thing into the particularity of his own experience, and his partial responsibility for both events and the course that his life has taken. The catalyst for construction of a personal narrative is sometimes the practical requirements of applying for a disability pension. The process of constructing a narrative invariably arouses intense emotions, particularly of grief, not only for comrades lost during and since the war, but almost always some mix of (a) irretrievable losses of pre-war relationships after return to civilian life, (b) ambitions, ideals, and relationships blighted by alcohol and drug abuse, and their consequences, (c) ambitions, ideals, and relationships blighted by violence and its consequences, (d) lost innocence, and (e) lost youth and health, waste.

This is not a smooth process, but one that cycles through periods of renewed testing, sometimes with breaks in safety, sobriety, and self-care, which must then be restored. In the group therapies leaders serve to assure "air time," and safeguard the VIP culture that every person's suffering is significant and cannot be measured against any other person's suffering. The

VIP tradition strongly discourages “pissing contests.” We monitor the emotional state of the veteran making the disclosure, as well as that of other veterans who may be triggered by it. Very often, the first disclosure of traumatic material occurs in individual therapy, and is only later taken into a group. In imparting fragments of trauma narrative to the group, veterans experience, “My story has meaning and value to others. I can trust them to understand and remember it. They are trustworthy witnesses to my grief, rage, and guilt and experience enough of these emotions with me that I know I am understood.”

### Stage III: Reconnection

The first two stages of recovery turn the veterans inward both toward themselves and toward the other veterans in the VIP. In the third stage, veterans selectively reconnect with people, activities, ideals, ambitions, and group identities from which they had become isolated, or make new connections. The core of this is the negotiation of safe, non-violent attachments in the family. This often entails reunion with, or renegotiation of relationships with, long-estranged children and parents. Sometimes the ruptures are irretrievable, or have been rendered so by death. When Odysseus meets the ghost of his dead mother in the underworld, he learns she died of grief during his long inexplicable vagrancy after the end of the Trojan War. This can be taken as a metaphor of such irretrievable losses that veterans must now face after their protracted, tormented *nóstoi*, “homecomings.” The veterans of VIP strongly support a therapeutic culture in the program aimed at preventing the intergenerational transmission of trauma (Ancharoff, Munroe, & Fisher, 1998)—support born of guilt and sorrow at the damage that they did in past years to parents, spouses, and children.

Some veterans, by no means all, have taken satisfaction in educating youngsters on war, or in active peace advocacy. Several engage in regular volunteer work with homeless veterans, particularly those who have recently been homeless themselves. A great many have participated in educational activities for mental health professionals at various levels, as well as medical students.

We have already spoken of “validation,” which plays important and varying roles in all three stages of recovery. The veteran community offers other resources that cut across all three recovery stages. These stages involve (a) “venting” the full range of feelings associated with trauma and its aftermath, (b) “value” that comes from having something to give to others, and (c) “views” that are disparate from and even contradictory to those of any given traumatized veteran, but held and expressed by someone the veteran nonetheless continues to treat with respect, usually another veteran.

One of us (Munroe, 1996) has called these four—validation, venting, value, views—the “four Vs” offered by the veterans’ community. We have been influenced in the way we conceptualize the dimensions of recovery by Mary Harvey’s account (1996) wherein she stresses authority over the remembering process, integration of memory and affect, affect tolerance, symptom mastery, self-esteem and self-cohesion, safe attachment, and meaning-making. We do speak to our patients of these dimensions as future, expected results of treatment—in concrete language arising from the veteran’s own experience. All of our patients struggle against chronic despair. One cannot “give hope” of recovery, without giving understandable content to that hope. Over a period of time, veterans readily understand Harvey’s dimensions of recovery.

## DEFINING CONCEPTS AND PRACTICES OF THE VIP TEAM TREATMENT MODEL

### Restoration of Community

*Community Is More Than Any Number of Dyads.* Basic trust (J. M.’s preferred term), social trust (J. S.’s preferred term), the capacity to attach to a community, requires at least three people. We are not playing logical games when we say that the dyadic trust between two people, no matter how many times it is pair-wise created, does not make a community. A community begins with the addition of the third person, and with the belief of each individual that when alone together the other two will continue to safeguard the interests of each even when that person

is absent. The trauma-world assumption is that they will plan some exploitation or attack. Good-enough nurturance in childhood produces basic trust as a matter of course; bad-enough trauma *at any age* destroys it. We feel that the main task in treating combat complex PTSD is to create a family of re-origin (Munroe, Shay, Makary, Clopper, & Wattenberg, 1989) where the veteran can relearn basic trust.

**Suspicion of Words.** It is not enough to talk about trust and tell patients verbally what they need to do. Vietnam combat veterans, like veterans of many other wars and other traumatized populations, were deceived by words as part of their trauma. Our patients were told many idealistic things about the war, but were not told of the horrors. They were told about codes of conduct, but they quickly saw that the rules did not apply. They were told the enemy was weak and ill equipped, but they saw how competent the enemy's tactics and weapons were. They were told in many voices that it was noble to be a warrior and that they would come home as heroes, but they learned they were not wanted. Veterans learned not to trust words, but to observe behavior. They observe the behavior of therapists who profess to offer therapy. They observe how well the therapist models basic trust.

### Tests of Trust

Our patients with complex PTSD, like good researchers, skeptically assume that there is no trust among professionals, and proceed to test this assumption. This is their "null hypothesis." The veterans replicate and re-test any finding that there *is* trust with many variations before they draw firm conclusions. The trauma worldview—"expectancy of exploitation"—is well-founded for survivors. They view evidence to the contrary with suspicion.

These testing procedures are well known to therapists—impatiently endured as obstacles to therapy. For combat trauma survivors with complex PTSD, these tests are the therapy. Therapists who are in a hurry and expect the survivor to be past this stage will guarantee their own ineffectiveness, missing opportunities to establish the infrastructure of trust nec-

essary for further therapy. Once the survivor "experimentally" confirms that the therapist is untrustworthy, the perceived relationship reverts, by default, to mutual exploitation. Survivors then cycle endlessly through suspicion and testing. The survivor will manipulate to get whatever is expedient, such as a medication that makes him feel good, a letter to divert bill collectors, help with disability compensation, getting him out of trouble, or a place to vent out rage. In our experience, without basic trust, therapy will never move beyond these points.

Tests of trust generally fall into four categories: (1) boundary maintenance, (2) professional trust, (3) secondary trauma ("compassion fatigue," Figley, 1995), and (4) therapist self-care (Munroe, 1995; Yassen, 1995).

**Boundary Maintenance.** The traumatized combat veteran, who has observed the repeated violation of rules and boundaries without sanction, is keenly interested in whether the professional community can police its boundaries. Tests might revolve around the time that sessions start or stop, times outside of scheduled sessions, how threats or intimidation are handled, or whether violations of rules are condoned. Wherever lines are drawn, veterans venture across them. The test is not so much about where the lines are drawn but rather, how the community deals with violations. Are the consequences clear, and will the community enforce them? Veterans also test to determine whether the rules are fair and how the team responds if rules are demonstrated to be unfair. Can the team acknowledge error and correct it or will clinicians deny it and blame the patient? For the veteran, unclear boundaries, irrational rules, and inflexible authorities who will not listen are reminiscent of the war zone and become triggers for intrusive and hyperarousal symptoms.

**Professional Trust.** Veterans observe how treaters treat each other. Our patients create tests to discover if we trust the other members of the team. It is very difficult for civilians to grasp the mortal stakes that enlisted men have in their officers and NCOs trusting each other in combat: When it's not safe for a junior leader to tell his boss the truth, people die.

Control of information (including disinformation) and of emotional self-presentation are powerful social techniques for survival in extreme situations. These are the principal means by which trauma survivors split therapists from each other and from their institutional setting (Munroe, Shay, Fisher, Makary, Rapperport, & Zimering, 1995). Splitting maneuvers usually seek out the actual ecology of power in the treatment setting. These often include trying to get one therapist to agree that another is incompetent or uncaring. They may also give conflicting information to different team members to see if they will communicate. Sometimes veterans engage one therapist to disagree with the treatment plan of another, or they ask about various theories or treatment approaches favored by others. Members of the team are pitted against one another on whatever issue is convenient.

These maneuvers can be directed at existing staff tensions, such as occupational or gender rifts, or treatment issues where there is plenty of room for different approaches. The content is secondary to testing whether professionals trust each other and can work out disagreements. It is an excellent opportunity for clinicians to model trust by openly dealing with splits. VIP team practices require forthright exchange of information and expression of feelings among team members and aim to make it safe for team members with different degrees and kinds of power to struggle together.

Splitting is a fundamental survival skill in a situation of captivity—which, modern combat is. As an adaptive move it plays one powerholder against another and gets them to fight with each other, or gets one to ally with the captive against the other. Splitting moves are complex strategies that control the information (and disinformation) the splitter gives on both fact and emotion, presenting one picture to one person, and another picture to another. The usual aim is to insert a wedge into an already existing fault line in the ecology of power and open it up into a chasm. The veteran who splits is not evil—he is simply applying his survival skills.

The team, when working well, assists its members in managing the powerful emotions aroused by splits. Falling for the “positive” side of a split is intensely pleasurable and inflating—almost everyone

doing this work for any length of time has experienced near hypomania from being on the “positive” side of a split. A clinician who buys into this loses the veteran’s trust as surely as the angry, counter-attacking clinician on the “negative” side of the split, who has fallen into that. The clinician who takes in the “negative” side of a split as a valid judgment, can descend into painful despondency and self-doubt. Clinicians who have known and liked each other for years find themselves flaring in naked hatred. The tensions and animosities that successful splitting creates can injure therapists and are a major cause of secondary trauma.

Here we want to remind readers that they should critically examine whether our experience in a long-term outpatient setting is suited to the character of their population, staff, and institutional setting. It is entirely possible, for example, that the staff of an inpatient setting with little control over their own intakes, a short length of stay devoted to “stabilization,” and with no meaningful enduring relationships among the veterans or between the veterans and staff, would be much better served by a clear and rigid hierarchy of power than the fluid, egalitarian structure that works well for us. We are not recruiting disciples.

There is no possibility of removing the differences among team members that veterans exploit to create splits. This would deprive the team and veterans of diversity, even if it were possible. Working alone in private practice cannot eliminate splits, because splits can always be engineered between the therapist and other patients, health insurers, police, the therapist’s family.

**Secondary Trauma (“Compassion Fatigue”).** Secondary trauma, psychological injury to the caregivers from doing the work, is intrinsic in the work itself. In our view, no degree of training, no degree of personal maturity, no perfection in the termination of a personal psychoanalysis, no perfected personal virtue or religiosity can protect an isolated mental health worker in any discipline from secondary trauma. A workplace community of trust, support, and safe struggle confers protection. And even that is not absolute. In public health terms, a well-functioning team provides secondary prevention of secondary trauma:

It prevents injury from becoming permanent and disabling by supporting recovery *pari passu* with the injury, but does not remove the injurious factor from the environment (which would be primary prevention).

Work with trauma survivors may injure therapists through three mechanisms:

1. The patients' narrative of traumatic life events make the therapist a witness to atrocities. The VIP model of team function allows its members to communalize these trauma disclosures with the team. Therapists' emotional and physical reactions to things heard are expected and normal, and are valuable clinical data. Unless the patients' material is "processed," i.e., communalized, it will injure the therapist. This is an Occupational Health and Safety practice in the workplace, not "group therapy."

2. Veterans with complex PTSD perceive the clinic in terms of situations in which they were injured and apply survival skills and strategies that were adaptive in the past traumatic situation. Common examples of these strategies are intimidation and splitting. Taken together, trauma-based ways of perceiving and adaptive strategies add up to re-enactment of trauma themes. As they play themselves out, these can be extremely damaging to the therapist.

3. When a treatment team is in continuous contact with a community of veterans, processes occurring in the veteran community develop in the treatment team as well. Because these processes manifest a worldview that assumes exploitation and victimization—sees everything in an us-against-them light—the worldview of the therapists can be damaged.

Occupational psychological injury to trauma workers has also been called vicarious trauma (McCann & Pearlman, 1990), secondary trauma (Catherall, 1992; Munroe, 1991; Rosenheck & Nathan, 1985), and countertransference (Wilson & Lindy, 1994). Danieli, a pioneer in demonstrating the importance of countertransference and secondary trauma in work with Holocaust survivors since 1980, has reviewed this subject in 1994.

Trauma survivors are well aware that reporting their stories affects those that hear them (Munroe, Makary, & Rappaport, 1990). They are very interested to see how therapists protect themselves from

this exposure. They look for ways to do this, as a model for how they should deal with their own trauma. They will often say such things as "I can't tell my wife about these things," or "my last therapist cried or changed the subject when I brought these things up." We often see a veteran vacillate between overexposing others to his traumas—so someone will understand—and keeping it all to himself to protect others from the fate of experiencing these events. How the clinician handles this is of primary interest to combat survivors. If they observe that therapists deny the impact and keep it to themselves, therapy is unsuccessful. If they observe that professionals acknowledge the effects and help each other as a community, they have a model for recovery.

Trauma survivors frequently test whether the therapist is isolated or engages the support of a community. We regard the standard image of the expert clinician who acts alone and is not bothered by trauma material to be detrimental to the veteran because it implies that if he were as well-informed, well-educated, or otherwise as strong and fortunate as the therapist, there would be no symptoms of PTSD. There is good empirical evidence that therapists are not immune from the effects of their patients' trauma material (Chrestman, 1994; Kassam-Adams, 1995; Munroe, 1991; Pearlman & MacIain, 1995; Schauben & Frazier, 1995) and therefore an image of invulnerability is counter-factual. Knowingly to pass it on to students and trainees is unethical.

**Therapist Self-Care.** For war veterans, trustworthiness in combat was measured by whether one would risk his life for the other. In the clinic, veterans frequently induce therapists to move toward extremes of demonstrating the sacrifices they will make. Therapists often get caught up in trying to rescue trauma survivors at their own expense. However, in doing so they model devaluing their own worth and they reenact the trauma theme of exploitative or lethally self-sacrificial relationships. This can take the obvious form of placing the clinician in the position of rescuing the patient from a suicide attempt, or more subtle forms such as moving appointments around, bringing up important material at the end of sessions, or calling the therapist at home or on week-

ends. The test is whether the therapists will allow themselves to be abused. Crises do occur in the normal course of treatment, and this is often where the real therapy begins. If clinicians are unable to practice self-care, the survivor is unlikely to take them seriously. Crisis intervention may be necessary, but the issue is safety, not therapy.

Survivors may also ask self-care questions directly, such as when the therapist takes vacation, or how he or she handles all the trauma material, or what the therapist does to relax. Conventional training in most mental health disciplines teaches us to turn away these questions as diversions from therapy or inappropriate intrusiveness into the life of the clinician. However, these are opportunities for direct modeling of self-care. Survivors require that therapists practice what they preach. In VIP, we can truthfully answer these questions by reference to the team.

### Team as Community and Team Plus Community

The VIP veterans now have a strong system of rules, devoted primarily to safety, sobriety, and self-care, developed over many years by the veterans, and mainly enforced by them in cooperation with the treatment team. The community rules are continuously a work in progress. The core of VIP is its group therapies. However, we use a "behavioral" point system as well, which awards points for attendance, constructive participation, and other pro-recovery activities. The point system embodies the principle that each veteran earns his place in VIP by his efforts toward recovery and by the contributions he makes to the recovery of others. Failure to make point requirements leads to mandatory meetings with the team as a whole. Persistent non-participation leads to discharge from the program. Despite periodic complaints that the point system is childish, petty, "chickenshit," or demeaning, the veterans support it as a means of making sure that the team is paying attention, and that the veterans have not been forgotten as members of the community.

We believe that rebuilding the capacity for trust is a process of re-socialization. Like the child's socialization in his original family, the ways team members conduct themselves toward each other—their

capacity to negotiate, the uses and abuses of power, mutual accommodation through expression and understanding of emotion, the trustworthiness of words, how they support or defeat each other's self-care—are an essential part of the VIP team treatment model. The famous aphorism of Sarah Haley (1974), "The therapeutic alliance is the therapy," can be adapted as "The team is the treatment."

### The Rhetoric of Treatment for Combat PTSD

We see ourselves engaged with the veterans as our fellow citizens of a democratic polity, which puts us squarely in the territory described by Aristotle in the *Rhetoric* (Rorty, 1996). We are going for the veterans' trust, to establish ourselves as trustworthy. In this context of free citizenship, Aristotle says—correctly in our experience—we have three interrelated means of achieving their trust. This involves appeal to their reason (*lógos*), appeal to their character (*êthos*), and appeal to their emotions (*páthos*). These are not separate, because reason pertains primarily to means, while the ends of action arise from the ideals, ambitions, and affiliations—which is to say, the character—of the veterans, and their emotions arise primarily from their cognitive assessments of the improvement or deterioration of these commitments. In this context, how we formulate our appeals gives evidence to them for our character, and in particular gives the veterans evidence of our good sense (*phronêsis*), personal integrity and competence (*aretê*), and good will for and toward the veterans we are persuading (*eunoia*). The centrality of persuasion, rather than coercion or deception, is a manifestation of the team's respect for our fellow citizens, these veterans, an aspect of our good will. What arguments and examples we choose from the infinity available, and how we develop them, provide evidence for our *phronêsis* and *aretê* and overall provide evidence for our own character. The persuasive power of sincere appeals to reason comes more from the evidence which it provides for our respect toward the veterans than from any intrinsic ability of reason to compel assent, or having compelled assent, to guide or restrain behavior. This, too, is one of the points Aristotle makes in the *Rhetoric* (Garver, 1994b, pp. 139–171, "Why Reasoning Persuades").

One aspect of *aretê*, integrity, and competence—excellence in general—calls for comment here, both because it seems critical to a combat veteran's feeling safe in the treatment program, and because it throws light on the clash between the ethos of the professional and what it takes to work with this patient population. This dimension of *aretê* in the clinician is a matter of the clinician's *thumós*. To trust the person offering care, combat veterans need to feel that this person is his or her "own person," not a slave to the rules, goals, and authorities of the institution in which he or she serves. (The word "slave" is not used lightly as a cheap hyperbole here—see Garver, 1994a.) The veterans' fearful sensitivities on this are understandable in terms of their real experience in war, when a leader who gives blind obedience to an irrational or illegal order can get the soldier killed or irretrievably tainted by commission of atrocities. Many tests of trust are set up as splits between the clinician and his or her boss, institution, professional code of ethics, licensure, and reimbursement rules. While there is an occasional veteran who appears to be saying, in effect, "I can never trust you unless you are an outlaw like me," most are satisfied with knowing that we personally and freely (not slavishly) support the substance of the rules.

We are open in our persuasion and also open to persuasion, when what we recommend, or an action that we take, seems wrong-headed or unjust to the veteran. Aristotle's account of persuasion, of reaching for trust, is useful and unsentimental—so long as we look back to the context in which we seek trust: We are in this together and are parts of each other's future as fellow citizens.

What we do is political in the richest senses of the word. We foster community among the veterans and join that community to the community of the treatment team. In doing so we establish the possibility of attachment to the larger social world because we (the treatment team) sincerely believe in that larger world and show that it is possible to participate in it with perceptive good judgment. We must do this as *rhêtor*—a citizen openly and undeceptively seeking the trust of fellow citizens and sharing in their fate—not as hireling sophist or as a slave of the insti-

tution and its rules. We speak to the veterans as free fellow citizens, not hired agents of social control or slaves of the state. The veterans know that we all receive VA salaries, and are more or less currently dependent on them for our livelihoods, but all team members have truthfully made it clear that we could be working elsewhere, and do this work because we want to, and choose to, not because "it's a paycheck."

Our work is political also in the sense that we encourage the veterans' participation in the democratic political life of the country that they fought for. As one of us has pointed out (Shay, 1995c), unhealed combat trauma disables the basic social and cognitive capacities required for democratic participation. As such, we strive to enable our patients to keep appointments, experience the world as trustworthy, explore the possibility of persuasion, negotiation, compromise, to explore the possibility of winning without killing and losing without dying, and to see the future as real and meaningful.

The team is also publicly and politically active in education of other mental health professionals on trauma treatment in general, and work with combat veterans in particular. The veterans have participated with great satisfaction in video education projects for mental health professionals—one such video formed a presentation at a professional meeting. As a whole team we have published and presented at professional meetings, with full knowledge of the veteran community. One of us (J. S.) publicly testifies on veterans' concerns at Congressional hearings, lectures and organizes conference panels on prevention of psychological injury for active duty military audiences, writes for the trade press, and does media appearances on the themes of combat trauma and on prevention of psychological injury in military service. The veterans in VIP are particularly supportive of these "missionary" educational and hortatory activities to the active duty military. They don't want other young kids to be wrecked the way they were wrecked.

We see these public and political activities as integral to the treatment; in terms of Aristotle's analysis, as a team we achieve trust on the basis of our character, and our public activities are one evidence of our character.

## Summary of VIP Team Practices

In effect, our VIP stresses the following precepts:

- Authority resides in the team, not in any single individual.
- Functional roles among team members are intentionally blurred and traded from time to time.
- Hierarchy empowers some to speak and silences others, empowers some for the possession of information and forbids it to others. The team acknowledges *no* hierarchy within itself, and strives for working equality of team members.
- Feelings are essential discourse among team members. These include feelings and countertransference experiences aroused by the patients' traumatic material, feelings toward the patients, and, most important, feelings aroused between team members. The latter is essential to uncover and heal splits.
- The goal of team process is clarity, not unanimity. A team accustomed to safe, affectively honest struggle will not remain split. A team has been successfully split when there is an unacknowledged disagreement, negative emotion, or adverse value judgment within it.
- Team members with different degrees and kinds of power are encouraged to struggle together. The goal of the team culture is to render this safe. The slogan, "Safe Struggle," places equal emphasis on both words.
- Veteran information is shared among the team, along with the feelings aroused in the clinician toward the information, toward the veteran, and toward others working with the veteran.
- More than one team member is always actively working with the veteran—this is important protection for both the therapist and the veteran.
- Therapist self-care is essential to work with survivors of severe trauma. The team culture encourages this self-care. It actively works against the constant pressure on therapists to become rescuers who are out there all alone with the veterans. The by-word is "I need to know you are taking care of yourself, for me to do my work."

- Multiple relationships and value commitments outside the team are essential to individual well-being and to prevent the team from becoming a totalitarian cult. The team strongly supports value-richness and views workaholicism as a failure of self-care, a sign of injury.
- The team model is inherently vulnerable to impairment by *any* of its members, regardless of the degree and kinds of power that person has from institutional or other sources. Team trust is thus fundamentally dependent upon unanimity of support for the team model itself—even though the team model encourages forthright disagreement over any other issue.

## DIVERGENCES IN THE TEAM MODEL FROM THE VALUE PATTERN OF THE PROFESSIONAL

The VIP team model for long-term treatment of complex PTSD after combat is difficult for mental health professionals to carry out because it diverges from the psychologically internalized and socially institutionalized value pattern of the professional in our society. Most parts of this value pattern seem so pervasively "true" that they are as invisible to us as water is to a fish. We shall attempt to bring them to awareness using the classic description given by Talcott Parsons (1951, p. 343 and other references indexed under "pattern variable"). His description is still on the nose, as not much has changed.

Parsons analyzed this professional value pattern through a series of dichotomous variables, and claimed that any given social position (such as "doctor") could usefully be characterized by the particular pattern of value commitments the person in that position is expected to fulfill. Parsons' dichotomous value "pattern variables" were universalism/particularism, functional specificity/functional diffuseness, collectivity orientation/self-orientation, achievement/ascription, affective neutrality/affectivity. We shall take up each one in turn and show how it obstructs the creation of trust in our population of combat veterans for whom the destruction of the capacity for trust is the most disabling aspect of their injury. Centuries of historical change and struggle lie behind each pattern variable,

not only institutionalizing norms that serve the interests of powerholders in modern industrial societies, but also often institutionalizing fairness, rationality, and protection for the powerless. Why should combat veterans react so badly to clinicians' loyal adherence to them?

### **Universalism (Opposite: Particularism)**

A mental health professional is expected to relate to a patient on the basis of technical rules governed by having identified the patient as a subsumable example of an abstractly defined category. Once the VA has applied the rules declaring a man or woman to be a "veteran" and "eligible," the mental health professional applies an institutionalized set of rules known as "diagnosis" to the patient's history and current life. We believe that these abstract, universalistic standards are claimed to "transcend" the particularity of the patient's history, situation, and future. Many combat veterans (especially at the beginning of their treatment when trust is absent) vocally resent being lumped with incest survivors, concentration camp survivors, auto wreck survivors, battered women, who are all conceived as having the "same" diagnosis. The veteran's angry insistence upon the therapist knowing the specifics of his military service, upon knowing who the 1<sup>st</sup> Battalion, 9<sup>th</sup> Marine Regiment were, is often taken by clinicians as a repellent narcissistic claim of "specialness." According to their professional training in the abstract universalistic system of diagnosis, and in the treatments claimed to be applicable to any exemplar of a diagnostic class, the clinicians are doing the right thing. Why does this veteran so perversely insist upon "being treated like an individual," when in the mind of the clinician, the veteran "ought to know" that scientific professionalism will provide him with the best possible outcome based on his universalistically defined diagnosis, not on the accidental particulars of his life? Is this just ignorance, or narcissism?

The answer is usually fear. These veterans have had the real experience of lives being lost, and people maimed, when a person in a position of power "went by the book," rather than looking first very sharply at the particulars, and then applying the book to them

with flexibility and good sense. (Aristotle: "The doctor cures a particular [i.e., not universal] man" EN I.61097a13.). Most veterans will not insist that a therapist be or become a subject-matter expert on every technical detail of the Vietnam era military, but only that the therapist be willing to "listen." Universal rules were sometimes—in reality—what got people killed.

### **Functional Specificity (Opposite: Diffuseness)**

"Division of labor" and "specialization" are often thought to be crowning achievements of the historic process of modernization. It is deeply ingrained in our common sense and institutionalized in law and in work rules. The voice of common sense says, "You do your job, and I'll do mine, and together we'll get the work done." Functional specificity is largely invisible to us as a value posture; we experience it more like a feature of the natural landscape, like gravity. Many readers may be scratching their heads wondering how the division of labor between, say, psychiatrists, psychologists, nurses, and social workers, could possibly be a trust issue for combat veterans.

In fact, the division of labor is a key element in the processes that support state-sponsored atrocities and torture (Kelman, 1994). Veterans who had the misfortune of witnessing or participating in these were told, "none of your business," or "not my job," or "just do your job" if they raised questions. Many of those who crossed into the heart of darkness are now dead by their own hand.

Probably the most frequent "boundaries" that combat veterans openly or subtly demand we cross—as a test of trust—are the boundaries of functional specificity, professional specialization, division of labor. Masters-level counseling psychologists are importuned for advice on medication; psychiatrists are pressured to locate Section 8 housing, and so on. No wonder well-socialized mental health professionals see these patients as demanding and narcissistic. However, the engine behind these demands is fear, not vanity. In the VIP team we intentionally blur disciplinary lines, and each of us strives to see the whole veteran as significant, with no predetermined limits to the dimensions of his welfare that are our concern.

Functional specificity is deeply institutionalized in licensure, departmental organization of the VA, and career paths in the professions. For many combat veterans with complex PTSD, the careerism of officers, the career management systems of the military services (manifested then as six-month rotations in troop command positions), were the visible sources of their betrayals.

### Collectivity Orientation (Opposite: Self-Orientation)

In the professionalized, bureaucratic society of "modernity," *thumós* (i.e., spirited self-respect) is not completely erased, it is tamed and channeled into the institutions (collectivities) of the society. One expects to find identity, satisfaction, pride, recognition, accomplishment, solidarity—but also material compensation—embodied in these institutions. Collectivity orientation channels ideals, ambitions, and affiliations through collectivities, not through personal relationships. The dichotomous opposite that Parsons chose for his jargon, "self-orientation," begs to be read simply as "selfishness," even though he carefully defines it in less moralizing terms. The moralizing is not completely off-base. Examples of corrupt self-orientation would be personally taking money from a VA patient to perform a clinical or administrative service one ought to be doing anyway. Under the normative value pattern variable, the mental health professional may receive his material compensation only from the collectivity. Or if a clinician became romantically, sexually, or narcissistically involved with a veteran, this would be a clear example of self-orientation, taking gratification from the specific relationship with the veteran rather than channeling all gratification through the collectivity and in the licit forms that the collectivity grants. These are the easy cases.

It gets murky when the veterans' welfare matters to the clinician more than that of his or her employer, or the veterans' esteem matters more than the esteem of professional colleagues. Such a mental health professional is likely to find him- or herself under suspicion by colleagues and supervisors, even if no steps have been taken in the real world that impair the insti-

tution or reject the colleagues. It's not hard to detect the lack of a collectivity-orientation; the professional who lacks it is "not with the program."

During the Vietnam War, officers who resisted rotation out of dangerous troop command billets at the end of their six months were labeled as having "gone native," that is, having developed more commitment to the troops than to the officer corps and to personal career advancement. This label was a career-ending stigma. Ironically, in some instances it was ideals of purely professional competence that led to such refusals, because the six-month rotation policy guaranteed that no one in command of a company or battalion had the time to learn what they had to learn to do the job well—in purely military terms.

The veterans we treat, who are all enlisted men, treasure the memories of the officers who were more devoted to their substantive military tasks and to the men under their command than to the reward system of their military service. More to the point clinically, any sign of collectivity-orientation by a clinician is liable to be a traumatic trigger, bringing back memories of having been put in lethal danger to get body count—or worse, to fill out the denominator of a kill ratio, where the presence of American casualties was rated as positive evidence of the commander's "aggressiveness" and "balls."

The urgency of fear lies behind the veterans' need to know that we are working in VIP because we want to, because it gives us personal pleasure and satisfaction for its own sake. Parsons would probably have called this "self-orientation" rather than "collectivity-orientation."

This pattern variable also has a subtle influence on the interactive style of clinicians. Normative avoidance of "self-orientation" seems to call for a degree of modesty in dealing with trauma survivors that may not serve the patients best. The narcissistic dimension of the veterans' injuries not only drives them to demand *timê* (Homer's heavy-freighted word for honor), but calls for the clinician to be able to accept with graceful good humor the idealizing, admiring reactions that veterans develop toward those whom at long last they have come to trust. Kohut (1971) was the first to point this out, and it accords with our experience. A clinician's professional colleagues are liable

to react negatively not only to the idealization itself, but to the reluctance of the clinician, the object of the idealization, to disparage and rebuff it as pathological.

### Achievement (Opposite: Ascription)

Modern clinicians attain to their professional credentials and institutional position through achievement of the standards of their respective disciplines. No one, least of all the injured veterans in the VA, wants to be treated by people whose only qualification is that they are a relative of someone powerful in the government, by some accident of birth. Such nepotism would be a textbook example of "ascription." "Achievement" is institutionalized in examinations, training program standards for accreditation, credentialing laws, and rules. The veterans do insist on competence—one dimension of the *aretê* (i.e., competence and integrity) on which they found their trust—so how does this normative value pattern variable get the mental health professional into a bind with combat veterans?

Again, fear is the problem. Veterans experienced lethal incompetence at the hands of officers and bureaucrats who had all the right credentials but whose competency in examinations and management science did not equip them for the reality of war against a resourceful human enemy who progressively figured out how to turn each textbook solution into a death trap. The veterans insist that there is something personal (read "ascribed") that makes someone trustworthy as a combat leader or as a clinician. Our institutions treat professionals who have the same "achieved status" evidenced by the same credentials as fungible—absolutely substitutable—for one another. The veterans reject this. Their trust is personal, non-transferable.

When you ask what personal quality made trustworthy officers worthy of trust, the most frequent answer is their willingness to listen. In the combat situation, it was willingness to listen to the particularity of the local and current knowledge of the most experienced person in the unit, regardless of rank. In the clinician, it is the willingness to listen to the particularity of the veteran's own experience. They don't ask us to be universal experts, and will be less trusting of a widely read clinician who is smug about this knowl-

edge, than of someone who knows the limits of what he or she knows.

### Affective Neutrality (Opposite: Affectivity)

The normative expectation that the professional will be emotionally detached, coldly rational, has been under attack for a long time and from many quarters, not the least of them being the recognition that even the simplest rational social judgments and self-restraints are flatly impossible for someone truly devoid of emotion (Damasio, 1994). The problem for our work lies less in some official insistence that professionals be affectively neutral, than in the difficulty of allowing emotions a full place at the table with our patients and our colleagues. One of us (Shay, 1994) has argued elsewhere that the communalization of trauma requires authentic emotion in the hearer of traumatic material. Even harder to overcome is the posture of affective neutrality in the presence of and toward professional colleagues. Yet, as we have explained above, treatment team members must make the emotions stirred toward each other by the veterans' splitting maneuvers a part of the team's work. The emotions stirred by veteran narratives, re-enactments, and tests of trust carry valuable clinical information, which is lost at everyone's peril.

### Are We Kicking Sacred Cows?

Some readers may wonder if a delight at kicking sacred cows is at work here. While neither of us is above such perverse pleasures, the main point of this review of Talcott Parsons' classic sociological analysis is to bring home the mismatch between our acculturation to professional norms and the psychological make-up of combat veterans with complex PTSD, and perhaps of any severe, human-caused prolonged trauma in a condition of captivity.

In her lucient analysis of the relationship of complex PTSD to the ecology of power, Judith Herman (1992b) has pointed out that professionals who devote themselves to the care of these patients risk becoming tainted and stigmatized by association with those whom the powerholders have victimized. In countries ruled by tyrants, this can be literal and life-

threatening, as when a general practitioner is questioned by the political police for setting the broken bone of the wife of an executed enemy of the state. In less extreme conditions it can be simple social ostracism, lack of otherwise merited recognition or advancement, and embarrassed discomfort of colleagues, such as Freud experienced when he took seriously the childhood sexual exploitation of his female patients. Judith Herman's observations stand firmly as the most important single thing to know about this matter, if we were limited to knowing but one thing about it.

Here, we have added a different sort of insight on the difficulties arising in the treatment of combat veterans with complex PTSD. These veterans may suffer unbearable terror when they encounter unthinking obedience by their caregivers to the normative value pattern of the professional. Even when these terrors can be allayed, the normative value pattern promotes the illusion of the invulnerable expert, able to work in social and emotional isolation—a Lone Ranger. This is a poor role model for the veterans, to whom we advocate the support and nourishment of a community.

### Aristotle Again—Human Is *Politikón Zôon*

We take seriously that the human being is a bio-psycho-social-cultural whole at every moment. This restates Aristotle's (4<sup>th</sup> century, BCE) zoological observation that the human is the animal of the political community. Body, mind, society, culture are not separate "realities," even less are they hierarchical "levels," which underlie each other, making some fundamental and others epiphenomenal. Our physi-

cal brains are biologically evolved to make us culture bearers and users; it is our biological nature to live in relation to culturally constructed moral codes; our social lives remodel our brains; cognitive assessments and their related emotional states influence bodily health, and so on. The very fact that we speak in terms of body, mind, society, culture is no more than a reflection of the methodological and institutional history of our intellectual worlds. They are temporary guides to perception and communication. They are throwaways, not eternal realities existing beyond the Platonic veil. What we do at this moment of writing and what you do at this moment of reading is at one and the same moment physiological, psychological, social, and cultural.

Given our experiences with traumatized Vietnam veterans, we believe that there is no conclusive and comprehensive theory of the human that sanctions the hegemony of any one mental health discipline's approach to our patients. As a clinical matter, our biopsychosocial-cultural understanding is in harmony with our multi-modal treatment that incorporates the practices of numerous schools of thought. To offer settings in which veterans can communalize despair and grief does not contradict offering the same veterans serotonin reuptake inhibitors, or making the group in which grief is communalized part of a "behavioral point system," or offering concrete assistance with public transport passes and disability pension hearings. This is not flabby eclecticism—it's the best we can do with the knowledge that we have. The distinction between "real treatment" and "mere support" blurs when we treat the whole person.

### REFERENCES

- American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). Washington, DC: Author.
- American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders* (3rd ed. Rev.). Washington, DC: Author.
- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.
- Ancharoff, M. R., Munroe, J. F., & Fisher, L. M. (1998). The legacy of combat trauma: Clinical implications of intergenerational transmission. In Y. Danieli (Ed.), *Intergenerational handbook of multigenerational legacies of trauma*. New York: Plenum.
- Carey, C. (1996). Rhetorical means of persuasion. In A. O. Rorty (Ed.), *Essays on Aristotle's Rhetoric*. Berkeley: University of California Press.
- Catherall, D. R. (1989). Differentiating intervention strategies for primary and secondary trauma in post-traumatic stress disorder: The example of Vietnam veterans. *Journal of Traumatic Stress*, 2(3), 289–304.

- Catherall, D. R. (1992). *Back from the brink: A family guide to overcoming traumatic stress*. New York, Bantam Books.
- Chrestman, K. R. (1994). *Secondary traumatization in therapists working with survivors of trauma*. Unpublished doctoral dissertation, Nova University.
- Damasio, A. R. (1994). *Descartes error: Emotion, reason, and the human brain*. New York: Grossett/Putnam.
- Danieli, Y. (1980). Countertransference in the treatment and study of Nazi Holocaust survivors and their children. *Victimology: An International Journal*, 5, 355-367.
- Danieli, Y. (1994). Countertransference, trauma and training. In J. P. Wilson and J. Lindy (Eds.), *Countertransference in the treatment of post-traumatic stress disorder*. (pp. 368-388). New York: Guilford Press.
- Erikson, E. H. (1959). Identity and the life cycle. *Psychological Issues*, 1(1, Whole No. 1).
- Erikson, E. H. (1963). *Childhood and society*. New York: Norton & Company.
- Erikson, K. T. (1976). *Everything in its path: Destruction of community in the Buffalo Creek Flood*. New York: Simon and Schuster.
- Figley, C. R. (1988). Post-traumatic family therapy. In F. M. Ochberg (Ed.), *Post-traumatic therapy and victims of violence* (pp. 83-110). New York: Brunner/Mazel.
- Figley, C. R. (Ed.). (1995). *Compassion fatigue: Secondary traumatic stress disorder from treating the traumatized*. New York: Brunner/Mazel.
- Garver, E. (1994a). Aristotle's natural slaves. *Journal of the History of Philosophy* 32, 173-195.
- Garver, E. (1994b). *Aristotle's Rhetoric: An art of character*. Chicago: University of Chicago Press.
- Haley, S. A. (1974). When the patient reports atrocities. *Archives of General Psychiatry*, 30, 191-196.
- Harvey, M. R. (1996). An ecological view of psychological trauma and trauma recovery. *Journal of Traumatic Stress*, 9, 3-23.
- Headquarters, Department of the Army. (1994). *FM 22-51: Leader's Manual for Combat Stress Control*. Washington, D.C.
- Herman, J. L. (1992a). Complex PTSD: A syndrome in survivors of prolonged and repeated trauma. *Journal of Traumatic Stress*, 5(3), 377-392.
- Herman, J. L. (1992b). *Trauma and Recovery*. New York: Basic Books.
- Herman, J. L. (1993). Sequelae of prolonged and repeated trauma: Evidence for a complex posttraumatic syndrome (DESNOS). In J. R. T. Davidson and E. B. Foa (Eds.), *Posttraumatic stress disorder: DSM-IV and beyond*. Washington, D.C.: American Psychiatric Press.
- Homer (ca. 800 B. C. E./1961). *The Odyssey*, Translated by R. Fitzgerald. New York: Random House.
- Janoff-Bulman, R. (1985). The aftermath of victimization: Rebuilding shattered assumptions. In C. R. Figley (Ed.), *Trauma and its wake* (pp. 15-35). New York: Brunner/Mazel.
- Janoff-Bulman, R. (1992). *Shattered assumptions: Towards a new psychology of trauma*. New York: The Free Press.
- Kassam-Adams, N. (1995). *The risks treating sexual trauma: Stress and secondary trauma in psychotherapists*. Unpublished doctoral dissertation, University of Virginia.
- Keane, T. M., Scott, W. O., Chavoya, G. A., Lamparski, D. M., & Fairbank, J. A. (1985). Social support in Vietnam veterans with post-traumatic stress disorder: A comparative analysis. *Journal of Consulting and Clinical Psychology*, 53(1), 95-102.
- Kelman, H. C. (1994). The social context of torture. In Ronald D. Crelinsten and Alex P. Schmid (Eds.), *The politics of pain: Torturers and their masters*. Boulder, Colorado: Westview Press.
- Kirkland, F., Halverson, R. R., & Bliese, P. D. (1996). Stress and psychological readiness in post-cold-war operations. *Parameters: Quarterly Journal of the U.S. Army War College* 26, 79-91.
- Kohut, H. (1971) *The analysis of the self*. Madison, Connecticut: International Universities Press.
- Lifton, R. J. (1967). *Death in life: Survivors of Hiroshima*. New York: Simon & Schuster.
- Lifton, R. J. (1973). *Home from the war: Vietnam veterans, neither victims nor executioners*. New York: Basic Books.
- Lifton, R. J. (1979). *The broken connection*. Simon & Schuster: New York.
- Mason, P. H. C. (1990). *Recovering from the war: A woman's guide to helping your Vietnam vet, your family and yourself*. New York: Viking.
- Matsakis, A. (1996). *Vietnam wives*. (2nd ed.). Woodbine House, Kexisington, MD.
- McCann, I. L. & Pearlman, L. A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress*, 3(1), 131-150.
- Munroe, J. F. (1991). *Therapist traumatization from exposure to patients with combat related post-traumatic stress disorder: Implications for administration and su-*

- pervision. Unpublished doctoral dissertation, available from Dissertation Abstracts, Ann Arbor, Michigan.
- Munroe, J. F. (1995). Ethical issues associated with secondary trauma in therapists. In B. Stamm, (Ed.), *Secondary traumatic stress: Self care issues for clinicians, researchers, and educators*. Lutherville, MD: Sidran.
- Munroe, J. F. (1996). The loss and restoration of community: The treatment of severe war trauma. *Journal of Personal and Interpersonal Loss* 1, 393-409.
- Munroe, J. F., Makary, C., & Rapperport, K. (1990). *PTSD and twenty years of treatment: Vietnam combat veterans speak*. Videotape presentation at the Sixth Annual Meeting of the Society for Traumatic Stress Studies, New Orleans, LA.
- Munroe, J. F., Shay, J., Fisher, L., Makary, C., Rapperport, K., & Zimering, R., (1995). Preventing compassion fatigue: A team treatment model. In C. Figley, (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized*. New York: Brunner/Mazel.
- Munroe, J. F., Shay, J., Makary, C., Clopper, M., & Wattenberg, M., (1989). Creating a family of re-origin: A long term outpatient PTSD unit. Presented at the Fifth Annual Meeting of the Society for Traumatic Stress Studies, San Francisco, CA.
- Nussbaum, M. C. (1986). *The fragility of goodness: Luck and ethics in Greek tragedy and philosophy*. New York: Cambridge University Press.
- Parsons, T. (1951). *The social system*. Glencoe, IL: Free Press.
- Patterson, O. (1982). *Slavery and social death*. Cambridge: Harvard University Press.
- Pearlman, L. A. & MacIain, P. S. (1995). Vicarious traumatization: An empirical study of the effects of trauma work on trauma therapists. *Professional Psychology: Research and Practice*, 26, 558-565.
- Pulver, S. (1970). Narcissism: The term and the concept. *Journal of the American Psychoanalytic Association* 18, 319-341.
- Rorty, A. O. (1996). Structuring rhetoric. In A. O. Rorty (Ed.), *Essays on Aristotle's Rhetoric*. Berkeley: University of California Press.
- Rosenheck, R. & Nathan, P. (1985). Secondary traumatization in children of Vietnam veterans. *Hospital and Community Psychiatry*, 36(5), 332-344.
- Schauben, L. J., & Frazier, P. A. (1995). Vicarious trauma: The effects on female counselors of working with sexual violence survivors. *Psychology of Women Quarterly*, 19, 49-54.
- Severo, R. & Milford, L. (1990). *The wages of war: When American's soldiers came home—from Valley Forge to Vietnam*. New York: Simon & Schuster.
- Shatan, C. F. (1985). Have you hugged a Vietnam veteran today? The basic wound of catastrophic stress. In W. D. Kelley (Ed.), *Post-traumatic stress disorder and the war veteran patient* (pp. 12-28). New York: Brunner/Mazel.
- Shay, J. (1992). Fluoxetine reduces explosiveness and elevates mood of Vietnam combat veterans with PTSD. *Journal of Traumatic Stress* 5, 97-101.
- Shay, J. (1994). *Achilles in Vietnam: Combat trauma and the undoing of character*. New York: Atheneum. Also (1995), New York: Simon & Schuster Touchstone.
- Shay, J. (1995a). About medications for combat PTSD. [On-line] Robert Hsiung (Ed.), *Psychopharmacology tips home page*. World Wide Web URL: <http://uhs.bsd.uchicago.edu/~bhsiung/tips/tips.html>.
- Shay, J. (1995b). Achilles: Paragon, flawed character, or tragic soldier figure? *Classical Bulletin*, 71, 117-124.
- Shay, J. (1995c). The birth of tragedy out of the needs of democracy. [On-line] *DIDASKALIA: ANCIENT THEATER TODAY* Vol. 2 No. 2, April 1995. World Wide Web URL: <http://www.csv.warwick.ac.uk/cgi-bin/mfs/01/didaskalia/issues/vol2no2/Shay.html>.
- van der Kolk, B. A., Brown, P., & van der Hart, O. (1989). Pierre Janet on post-traumatic stress. *Journal of Traumatic Stress*, 2(4), 365-378.
- Wilson, J. P. & Lindy, J. D. (Eds.) (1994). *Countertransference in the treatment of PTSD*. New York: Guilford Press.
- WHO [World Health Organization]. (1992). *The ICD-10 classification of mental and behavioral disorders: Clinical descriptions and diagnostic guidelines*. Geneva, WHO.
- Yassen, J. (1995). Preventing secondary traumatic stress disorder. In Charles Figley, *Compassion Fatigue*. New York: Brunner/Mazel.